2025 Illinois Certified Professional Midwife and Doula Workforce Landscape Analysis Report and Recommendations

Prepared by: Dr. Camille Williamson, LCSW
Editing support: Anna Yankelev, MPH, MBA
Survey Design Team: Mekazin Alexander, Chastity Mayes, Star August Ali, Nora Kropp

Executive Summary

Maternal mortality and morbidity inequities continue to be major public health challenges for the Illinois health care system and birthing people across the state. Upcoming funding cuts to Medicaid and maternal health services will further compound the structural violence, institutional racism, and variable access to care that contribute to these inequities. Despite the depth and complexity of these barriers to quality care, the utilization of doulas and Certified Professional Midwives (CPMs) offers an effective strategy to mitigate maternal health inequities across the state, especially for populations historically excluded from or exploited by our health care systems.

This report outlines an environmental scan of the doula and CPM workforces in Illinois. Doulas are trained professionals who provide continuous physical, emotional, and informational support to their clients before, during, and shortly after childbirth.[1] CPMs are knowledgeable, skilled professionals who provide clinical midwifery care to birthing people in their homes and birthing centers throughout prenatal, birthing, and postpartum periods.[2] This report refers to doulas and CPMs collectively as community-based birth workers and provides a snapshot of this specific workforce in Illinois in 2025, including an assessment of workforce needs to expand community-based birth worker provision of care throughout the state.

In addition, this project documents client demographic information, the scope of services offered by doulas and CPMs, professional development opportunities, compensation, experience with Medicaid enrollment, and integration in formal health care settings. This landscape analysis included quantitative survey data as well as qualitative data from focus groups and key informant interviews. The overarching goal of this research was to collect data that would inform the Illinois Community-Based Birth Justice Strategic Plan’s policy and practice recommendations for community-based birth workers in Illinois.

The analysis of the data supports the following recommendations:

1. Expand the capacity of the community-based birth workforce by increasing its size and expanding its reach to vulnerable populations and rural areas in Illinois.
2. Provide support and sustainability for this workforce by ensuring affordable professional development and offering a livable wage that establishes a clear, sustainable career pathway for current and emerging doulas and CPMs.
3. Foster better integration of community-based birth workers into health care settings and social support networks that improve the birthing outcomes for patients and support continuity of care.
4. Build power within the community-based birth workforce by including their perspectives and expertise in state-based policies for maternal and reproductive health.

Maternal Care within the United States and Illinois

Overall, the United States health care system and public policy do not center the needs of the most vulnerable birthing populations, leading to poor maternal health outcomes, experiences of systemic and structural racism, and traumatic birthing experiences. Additionally, our current hospital-driven provision of care may have put many birthing people at a disadvantage and greater risk during the COVID pandemic. Furthermore, the current federal administration has enacted sweeping changes that threaten maternal health programs, public health surveillance of maternal mortality and morbidity, and surveillance of underlying structural determinants of public health. Specifically, their proposed changes to the Affordable Care Act via the "Big Beautiful Bill" could leave 10 million people uninsured, including millions of people of reproductive age.[3]

Access to Perinatal Care Services

The United States ranks number one in maternal mortality amongst countries with similar economies, and it is important to note the difference in policy and practice methods for maternity care amongst the comparison group. Other high-income countries have federally mandated paid leave of 14 weeks or more for childbirth. In addition, many of these countries use a midwifery model to provide perinatal care for birthing people, including home visits. The United States has an overreliance on hospitals and physicians for perinatal care compared to other high-income countries. Currently, there are more Obstetrician-Gynecologists (OB-GYNs) than midwives in the United States. Moreover, there is a shortage of OB-GYNs, labor and delivery units, and birth centers in many rural and low-income urban areas, limiting access to perinatal care.[4]

In Illinois, there are only 690 OB-GYNs, most practicing in more urban counties within the state, according to the Bureau of Labor Statistics.[5] And although there are family practice physicians that also provide perinatal care,[6] the percentage of family medicine providers that provide pregnancy care has declined to below 10% across the United States.[7] Additionally, many Illinois residents reside in maternal health deserts. These low-income urban and many rural communities lack access to perinatal care and birthing hospitals, with more closures expected due to Medicaid funding cuts in the coming years. In fact, 34.3% of Illinois counties are classified as maternal care deserts, and 13 southern counties in Illinois have no maternal care providers at all.[8] In urban areas like Chicago, zip codes with low access to maternal care are exclusively in areas with a majority of Black or Latine residents. Overall, hundreds of thousands of Illinois residents are impacted by the shortage of physicians and hospitals that can provide comprehensive perinatal care as well as specialty care for high-risk pregnancies.

This lack of access has fatal consequences for some birthing people. Birthing people who do not have access to comprehensive prenatal care are more at risk for birthing complications and emergency department visits, especially those who live in maternal care deserts.[9] According to the 2025 Illinois Maternal Mortality Data Report, the leading causes of pregnancy-related deaths between 2021-2022 were substance use disorder at 29%; thrombotic embolism (blood clot) at 12%; COVID-19 at 11%, and hemorrhage (postpartum bleeding) at 10%. Other critical findings from

this report indicate that of the pregnancy-related deaths, 72% had “some chance” of being prevented, and 19% had a “good chance” of being prevented.[9] Upon further review, these health outcomes do not affect all communities equally. In Illinois, Black women were more than twice as likely to experience pregnancy-related deaths as White women.[10] In Chicago, Black women were over six times more likely to experience pregnancy-related deaths.[11]

In addition to the avoidable trauma, illness, and death that this lack of access produces, births complicated by maternal and infant morbidity and mortality cost millions of dollars more than healthy births. Therefore, Illinois must seek out and implement more perinatal care supports for birthing people, especially for those who experience poverty, discrimination, and low access to quality reproductive care.

Benefits of Community-Based Birth Workers

Data shows that access to community-based birth workers like doulas and midwives positively improves maternal and infant health outcomes, particularly for those experiencing intersecting barriers to care. Doulas provide services and support during home visits with pregnant people and in the delivery room while they are giving birth. Doulas have proven to be significantly effective in improving maternal and infant health outcomes, especially for pregnant Black, Indigenous, and People of Color (BIPOC), including demonstrated increases in vaginal births, breastfeeding rates, mental health, and decreased rates of low birthweight babies.[12] Furthermore, doulas establish a deep rapport with patients that allows them to effectively advocate for them during their delivery and provide stress relief to manage spikes in blood pressure. This is essential in addressing the maternal health crisis in Illinois, given the indicators of hypertension and pre-eclampsia as predictors of poor maternal-child health outcomes for BIPOC birthing people.[12]

Certified Professional Midwives are another key member of the community-based birth workforce. CPMs provide low-risk, low-intervention intrapartum care in birth centers and at home births, which may be the only delivery options for individuals living in health care deserts. CPMs are skilled and effective at providing cardiovascular and metabolic monitoring and other clinical assessments as needed for low-risk pregnancies. Importantly, CPMs are direct-entry midwives certified through accredited programs that have considerably fewer financial and time constraints than nurse midwifery programs, enabling CPMs to be trained and practicing more quickly than other providers. Both doulas and CPMs provide culturally congruent care in community settings, filling the gaps left by Illinois’ health care system.

Filling the Gaps: Current Community-Based Birth Workforce Needs

In 2023, there were approximately 2.5 million women of reproductive age living in Illinois,[10] and between 2020 and 2022, there was an average of 131,340 births per year.[13] Forty percent of those births were covered by Medicaid in Illinois, and 7.6% of women who are of reproductive age are uninsured.[14] Assuming that all those with public or no health insurance could greatly benefit from a community-based birth worker’s support, there are approximately 63,043 births per year in which

Medicaid recipients could benefit from access to a CPM or doula, especially since doulas and CPMs can now be reimbursed by Medicaid.[15]

The data from this landscape analysis indicates that one of the major challenges for doulas and CPMs is the ability to make a livable wage while maintaining a manageable client load. If a livable wage and reasonable workload were ensured for community-based birth workers, each worker (a doula or CPM) could serve an average of 36 clients per year. Based on the sample size of the quantitative survey and assuming the current community-based birth workforce is positioned to provide reproductive care to Medicaid recipients, they would be able to support 4,284 birthing people annually. In order to provide birth support to the remaining 58,759 birthing people on Medicaid, the workforce would need to grow by an additional 1,632 community-based birth workers. Even assuming these estimates are conservative, the need to dramatically increase the size of this workforce is clear.

To that end, this CPM and doula workforce landscape report provides essential data about the workforce itself, the clients they work with, and how to best support the growth and sustainability of these workers so that every birthing person has the support they need for a safe and positive perinatal experience. Ultimately, the data from this report will inform the Illinois Community-Based Birth Justice Strategic Plan's policy and practice recommendations for community-based birth workers in Illinois, as well as other relevant plans and initiatives.

The Illinois Community-Based Birth Justice Strategic Plan has determined a set of strategic plan priorities to facilitate this process, which include:

- Improving maternal care infrastructure by creating an integration playbook, supporting birth centers, and providing advocacy for community-based birth justice.
- Enhancing patient experience by increasing public education, promoting accountability and quality improvement, and creating a public resource and referral hub.
- Advancing and integrating the maternal workforce by developing workforce integration training, expanding the community-based birth workforce, and building a community-based birth justice workforce collaborative.
- Evolving funding for reimbursement and coverage advocacy, and launching a statewide birth justice funding and accountability framework to inform funding priorities and practices.

These priorities are complementary to Illinois' Blueprint for Birth Equity, which includes four strategic goals to improve person-centered care, expand access to maternal care, enhance continuity of care, and establish better accountability.[16]

Methodology

The Illinois CPM and doula landscape analysis was conducted in two steps:

1. Survey to learn:
    - Workforce demographics and locations

- The demographics they serve
- The services they provide
- Their training and professional development
- Their compensation and income levels
- Their experience with Medicaid and perspectives on reimbursement
- Their experience within formal health care settings

2. Focus Groups and Key Informant Interviews to learn:
    - Specific workforce issues related to education, training, and capacity
    - Accessibility of professional development
    - Additional perspectives on compensation and Medicaid
    - Barriers and opportunities to integrating into health care settings
    - Gaps in client resources
    - Personal needs for support and prevention of burnout

Both the quantitative survey and qualitative interview content were developed in collaboration by the evaluation consultant for this project, the Director of the Strategic Workforce Initiatives at Health & Medicine Policy Research Group, the Executive Director and Development Manager of the Black Midwifery Collective, the Executive Director of BA NIA Inc., and the lead doula of The Little Resource Center in Carbondale, Illinois.

Data Analysis

Quantitative Analysis

- The survey was launched on April 22, 2025, and utilized a convenience sample and snowball recruitment for completion. The survey was promoted in numerous maternal health email lists and associations for several weeks.
- Anyone working as a doula or CPM as their primary profession in Illinois was eligible to complete the survey.
- A $20 gift card was sent to individuals who completed the survey.
- 149 respondents accessed the survey
- There were 25 incomplete or blank responses
- There were 124 complete survey responses
- 105 doulas completed the survey
- 19 CPMs completed the survey
- The survey closed on July 7, 2025

The full survey tool can be found in Appendix A. Appendix B highlights the full quantitative analysis of the survey, including heat maps, charts, and graphs. The charts below provide an overview of survey results.

Table 1: Demographics and other characteristics of doulas working in Illinois (n=105)

Survey Data	Themes
Top Service Locations by County	• 64% Cook County • 21% DuPage County • 14% Will County
Racial Identity of Doulas	• 44% Black/African American • 41% White • 23% Latino/a/e/x or Hispanic **Respondents were able to select more than one race to indicate their racial identity*
Racial Concordance of Doulas and Clients	• 8% always serve clients of their race • 29% serve clients of their race most of the time • 32% serve clients of their race half the time • 30% serve clients of their race sometimes • 1% never serve clients of their race
Top Languages Spoken by Clients	• 79% English • 16% Spanish • 5% other languages **Respondents selected all options that applied*
Concordance of Language of Doulas and Clients	• 44% always speak the same language • 46% speak the same language most of the time • 7% sometimes speak the same language • 3% speak the same language about half the time
Gender of Doulas	• 92% women • 3% men • 5% non-binary **Respondents selected all options that applied*
Doula Sexual Orientation	• 73% do not identify as LGBTQAI+ • 27% identify as LGBTQAI+
Doulas Serving Clients That Identify as LGBTQAI+	• 13% often serve LGBTQAI+ clients • 35% sometimes serve LGBTQAI+ clients • 25% rarely serve LGBTQAI+ clients • 11% do not serve LGBTQAI+ clients • 16% are not sure if they serve LGBTQAI+ clients
Years in Practice	• 14% over 10 years • 22% 5-10 years • 23% 3-5 years • 29% 1-3 years • 12% less than a year

Top Types of Services Provided	• 96% birth support • 88% postpartum care • 83% prenatal care (support) • 71% lactation support **Respondents selected all options that apply to their scope practice*
Clients' Source of Payment	• 40% Medicaid • 32% other forms of payment • 14% private insurance • 14% not insured
Top Sources of Compensation	• 48% paid by employer (community program) • 24% paid directly by client • 10% volunteer
Top Doula Workplaces	• 57% work at community partnerships, groups, or collectives • 35% work independently
Vulnerable Populations Served	• 65% serve teens or young people • 57% serve domestic violence survivors • 57% serve unhoused people/people with insecure housing • 54% serve immigrants • 52% serve people with disabilities • 52% serve people struggling with addiction • 48% serve people with limited English proficiency • 47% serve formerly incarcerated people • 45% serve court-involved people (family court/DCFS) • 14% serve incarcerated people • 32% would like to serve these populations, but do not have the resources **Respondents selected all options that apply to their scope practice*
Clients seen in a year	• 48% serve 1-10 clients in a year • 28% serve 10-20 clients in a year • 11% serve 20-30 clients in a year • 7% serve 30-40 clients in a year • 2% serve 40-50 clients in a year • 3% serve over 50 clients in a year
Doula Capacity	• 45% never have to turn people away • 48% sometimes have to turn people away • 7% have to turn away clients about half the time
Clients Served Per Month	• 71% serve 1-5 clients

	• 21% serve 5-10 clients • 5% serve 10-15 clients • 3% serve over 20 clients
Location of services provided	• 41% in hospitals • 40% in client's home • 7% in birthing centers • 6% in health clinics • 6% other locations
State Certified Doulas	• 60% are state certified • 40% are not state certified
Top Doula Certification Training Sources	• 84% trained at a community/private organization • 32% trained at a national organization • 24% trained in an apprenticeship *Respondents selected all options that applied*
Cultural Sensitivity Training	• 95% received cultural sensitivity training • 5% did not receive cultural sensitivity training
Barriers to Additional Training	• 84% indicate costs are too high • 30% indicate trainings are not offered near them • 19% don't have time to attend *Respondents selected all options that applied*
Annual Income	• Average annual income is $34,302.56
Doulas Working to Supplement Income	• 63% work supplemental jobs • 37% do not work supplemental jobs
Doulas on Public Assistance	• 32% utilize public aid programs • 68% do not utilize public aid programs
Doula Medicaid Enrollment Status	• 47% are not enrolled • 32% are in progress of getting enrolled • 14% are enrolled • 7% are not sure if they are enrolled or not
Doula Opinion on Medicaid Reimbursement Rate	• 68% indicate the rate is insufficient • 32% indicate the rate is sufficient
Top Barriers to Medicaid Enrollment	• 31% indicate they do not have the knowledge or training to navigate the process • 17% indicate they are not aware of the option to enroll • 16% indicate that the option does not pay enough to be financially feasible • 14% indicate it is too much work to enroll *Respondents selected all that apply*

Doulas Experiencing Discrimination in Healthcare Settings	• 54% have experienced discrimination in health care settings • 46% have not experienced discrimination in health care settings
Doulas Experience of Integrating Services in Healthcare Settings	• 59% have had challenges integrating into formal health care and hospital settings • 41% have not had challenges integrating into formal health care and hospital settings

Table 2: Demographics and other characteristics of Certified Professional Midwives working in Illinois (n=19)

Survey Data	Themes
Top Service Locations by County	• 47% Cook County • 32% Lake County • 32% Kane County • 21% Dekalb County • 21% DuPage County
Racial Identity of CPMs	• 74% White • 21% Latino/a/e/x or Hispanic • 5% Native American • 5% Decline to Answer • 5% Other **Respondents were able to select more than one race to indicate their racial identity*
Racial Concordance of CPMs and Clients	• 65% serve clients of their race most of the time • 25% serve clients of their race sometimes • 10% serve clients of their race about half the time
Top Language Spoken by Clients	• 95% English • 37% Spanish • 5% Other languages **Respondents selected all options that applied*
Concordance of Language of CPMs and Clients	• 26% always speak the same language • 47% speak the same language most of the time • 16% speak the same language about half the time • 11% sometimes speak the same language
Gender of CPMs	• 83% women • 4% decline to answer **Respondents selected all options that applied*
CPM Sexual Orientation	• 84% do not identify as LGBTQAI+

	• 16% identify as LGBTQAI+
CPMs Serving Clients That Identify as LGBTQAI+	• 5% often serve LGBTQAI+ clients • 47% sometimes serve LGBTQAI+ clients • 37% rarely serve LGBTQAI+ clients • 11% do not serve LGBTQAI+ clients
Years in Practice	• 58% over 10 years • 26% 5-10 years • 5% 3-5 years • 11% 1-3 years
Top Types of Services Provided	• 100% postpartum care • 95% birth support • 95% lactation support • 89% prenatal care **Respondents selected all options that apply to their scope practice*
Clients' Source of Payment	• 29% private insurance • 14% Medicaid • 31% other sources • 26% not insured
Top Source of Compensation	• 57.7% paid directly by client • 10.5% paid by private insurance • 9.4% volunteer
CPM Workplaces	• 47% work at partnerships, groups, or collectives • 37% work independently • 16% work in other locations
Vulnerable Populations Served	• 94% serve domestic violence survivors • 76% serve teens or young people • 53% serve immigrants • 47% serve people with limited English proficiency • 41% serve people with disabilities • 35% serve unhoused people/people with insecure housing • 29% serve formerly incarcerated people • 18% serve people struggling with addiction • 12% serve court-involved people • 12% serve survivors of sexual assault/abuse • 47% would like to serve these populations, but do not have the resources **Respondents selected all options that apply to their scope practice*

Clients seen in a year	• 16% serve 1-10 clients in a year • 26% serve 10-20 clients a year • 26% serve 20-30 clients in a year • 5% serve 30-40 clients in a year • 11% serve 40-50 clients in a year • 16% serve over 50 clients in a year
CPM Capacity	• 37% never have to turn people away • 53% sometimes have to turn people away • 5% have to turn people away half the time • 5% have to turn people away most of the time
Clients Served Per Month	• 63% serve 1-5 clients • 26% serve 5-10 clients • 5% serve 10-15 clients • 5% serve over 20 clients
Location of Services Provided	• 59% in client's home • 19% in birthing centers • 9% in hospitals • 9% in health clinics • 4% other locations
State Certified CPMs	• 84% are state certified • 16% are not state certified
Top CPM Certification Training Sources	• 74% apprenticeship • 58% learned from a traditional midwife • 58% PEP process **Respondents selected all options that applied*
Cultural Sensitivity Training	• 100% of CPMs received cultural sensitivity training
Top Barriers to Additional Training	• 69% indicate costs are too high • 63% indicate trainings are not offered near them • 50% indicate they do not have time to attend **Respondents selected all options that applied*
Annual Income	• Average annual income $52,894.74
CPMs Working to Supplement Income	• 63% work supplemental jobs • 37% do not work supplemental jobs
CPMs on Public Assistance	• 16% utilize public assistance programs • 84% do not utilize public assistance programs
CPM Medicaid Enrollment Status	• 68% are not enrolled • 21% are in progress of enrolling (more than likely as a doula) • 11% are enrolled (more than likely as a doula)

CPM Opinion on Medicaid Reimbursement Rate	• 89% indicate the reimbursement rate is not sufficient • 11% indicate the reimbursement rate is sufficient
Top Concerns about Medicaid Enrollment	• 47% indicate the rate does not pay enough to be financially feasible • 37% indicate it is too much work to manage billing • 37% indicate they do not have the knowledge or training to navigate the process • 26% indicate it is too much work to enroll **Respondents selected all that apply*
CPMs Experiencing Discrimination in Healthcare Settings	• 89% have experienced discrimination in health care settings • 11% have not experienced discrimination in health care settings
CPMs Experience of Integrating Services in Healthcare Settings	• 100% have had challenges integrating into formal health care and hospital settings

Qualitative Analysis

Summary

- Three focus groups were conducted between July 15, 2025, and July 17, 2025
  - 11 doulas participated in 3 focus groups
    - 7/15/25 Focus group with doulas providing services in Cook County
    - 7/16/25 Focus group with doulas in providing services in counties surrounding Cook County and mid-state counties
    - 7/17/25 Focus group with doulas providing services in Southern Illinois
- Five key informant interviews were conducted between July 17, 2025, and August 18, 2025
  - 1 doula participated in a key informant interview
    - Doula providing services in Cook County
  - 5 CPMs participated in key informant interviews
    - CPMs providing services in Cook County and the surrounding mid-state counties
- A gift card of $100 was given to all participants of the focus groups and key informant interviews.

The charts below illustrate the themes noted across all focus groups and key informant interviews.

Table 3: Barriers, challenges, and opportunities identified by doulas working in Illinois (n=12)

Topic	Themes
Workforce Training and Education	• Experience challenges with getting certifications • Preference for more preparatory training that is “hands-on” with mentorship

	• Unprepared for COVID Pandemic
Work Capacity	• Some agencies that provide doula care may not be managed by birth workers, creating unrealistic expectations for workload • On-call structures for some doula organizations do not provide enough compensation for the sacrifice • Doulas must wear a lot of hats with clients, which can lead to burnout • Working with clients is enjoyable
Accessibility of Professional Development	• Need affordable, continuous training offered • Need professional development opportunities that are hands-on with online options • Need training that emphasizes cultural awareness
Compensation and Medicaid	• The current Medicaid reimbursement rate does not provide a livable wage • Grant funding for doula services doesn't seem sustainable • Current compensation does not incorporate all parts of doula labor • Compensation should be set to allow for a livable wage ($1,300-$2,000 per birth or full salary of $60, 000-$70, 000) • Possibly provide a different rate of pay for being on call
Barriers for Integration into Healthcare/Medical Settings	• There is need for better integration of birth workers and medical providers for better care of clients, especially those with special needs • Sometimes hospitals are welcoming to doulas ("about 50-50"), although there has been some progress • Doulas who have built rapport with medical providers have had better integration • There is a disconnect between the work of the doulas and medical providers (providers need to be better educated about what doulas provide to clients) • Black mothers experience racism in hospital settings (they are not listened to) • Some medical providers are too judgmental of birthing people that use substances
Opportunities for Integration into Healthcare/Medical Settings	• Hospital staff need training on empathy • Hospital staff need training on trauma-informed care • Hospitals need cultural sensitivity training • Clients need informed consent for birthing options

	• Clients need a better standard of perinatal care that includes well-paced pre-natal appointments, better translation services, and patient-centered approach • Medical jargon should be explained in clear terms • Medical visits should be “less rushed,” with fewer inductions at 39 weeks and fewer c-sections • Physicians should refer patients to midwives if they are not high risk
Gaps in Patient Resources	• Physicians don’t have enough time with patients, so processes and procedures get rushed and are “cookie cutter” • Birthing people need a village around them that has secure housing, nutritious food, and social support • Birthing people need reliable transportation • Birthing people need social work care and case management to address stressors and social determinants of health • Birthing people need access to parenting classes • Southern Illinois is a maternal care desert that needs more perinatal care options and accessibility • Birthing people need affordable childcare • All birthing people need access to comprehensive perinatal care
Personal Supports and Burnout Prevention	• Doulas need mental health support (collegial support groups and mentorship) • Doulas need childcare support • Doulas need manageable workload and collaboration with social work support networks • Stress levels can run high, so doulas need access to individual behavioral health supports • Doulas need recognition and celebration of good work being done • Many doulas work more than one job which can lead to burnout, so they need a livable wage

Table 3: Barriers, challenges, and opportunities identified by Certified Professional Midwives working in Illinois (n=5)

Topic	Themes
Workforce Training and Education	• Initial education and training can be brutal to get through • It is challenging to find clinical learning experiences in Illinois which can be isolating • It can be difficult to get mentorship

	• The midwifery field is dominated by white women
Work Capacity	• Most CPMs report being self-employed, without any organizational support • Sometimes CPMs must turn people away due to capacity limitations • CPMs have challenges balancing fair compensation with affordability of services • Being on call is exhausting, mentally taxing, and stressful for CPMs • However, CPMs note that the work is fulfilling
Accessibility of Professional Development	• There are no learning spaces that are representative of Black and Brown communities for CPMs • Training options meet medical training interests and requirements, but don’t address the mental health and social needs of client populations • Training can be expensive sometimes • There are not a lot of in-person training options available
Compensation and Medicaid	• Medicaid reimbursement rate has not been set, but CPMs are concerned about fairness of pay • CPMs are paid low wages • Compensation for CPMs should provide a livable wage without having to work other jobs • Compensation suggestions are $5,000- to $10,000 per birth
Barriers for Integration into Healthcare/Medical Settings	• Some CPMs find it challenging to transfer patients • Hospitals where there is a working relationship established may have more ease with transferring patients • CPMs often witness human rights violations • Although the working relationships with receiving hospitals have gotten a little better, some rural hospitals can still be challenging • Some physicians have a “god complex”
Opportunities for Integration into Healthcare/Medical Settings	• More care should be delivered in the home, similar to European models of perinatal care • There should be more accessible care at the community level • There need to be more racially representative providers for the full spectrum of the birthing workforce • Physicians need to spend more time building rapport with patients and listen to them more • Physicians need education on basic human rights

	• There needs to be more access to midwifery care as an option for perinatal care
Gaps in Patient Resources	• Birthing people need more accessible prenatal care, especially in rural areas • Patients need stable housing, nutritious food, and social support, especially for more vulnerable populations • Birthing people need educational resources on birthing, birthing options/choices, and childcare • Birthing people need less stress and less work while pregnant and postpartum • Birthing people need chiropractic care • Birthing people need lactation support • Birthing people need culturally congruent providers • Birthing people need a livable wage and access to affordable healthcare, and emergency obstetric care
Personal Supports and Burnout Prevention	• CPMs note it is rewarding to play a role in breaking the cycle of traumatic births • CPMs need non-toxic work settings for group practices • CPMs need administrative assistants to provide additional support • CPMs need mental health support • CPMs need family support which may include childcare and supportive therapy for children

Limitations

Data Collection

Currently, the state of Illinois does not uniformly collect data that clearly indicates the type and number of community-based birth workers (CPMs and doulas) by county, hence the focus of this project. Therefore, it is likely that some community-based birth workers did not participate in the survey. This initial data set will help determine a starting place for strategic planning and advocacy to grow, support, and sustain the community-based birth worker workforce to improve maternal health outcomes and meet the strategic priorities of the Illinois Birth Justice Coordinating Committee.

Survey Fatigue

Although the research team determined that the survey response rate was acceptable, there were similar surveys launched around the same time as the one for this project, which may have been

confusing for the CPM and doula workforce. Some community-based birth workers may not have taken the survey if they believed that they had already completed it from another source.

High Doula Representation

The survey sample provides an important snapshot of the community-based birth worker landscape; however, most responses were from doulas. Only 19 CPMs completed the survey, thus it is not recommended to generalize their responses to the overall midwifery workforce. Although there are only a total of 24 licensed CPMs in the state of Illinois, there may be other midwives in the process of becoming licensed or practicing more community-based midwifery, as well as certified nurse midwives, who were not included in the survey or key informant responses.

Low Turnout for Focus Groups and Interviews

Lastly, the response rates for focus groups and key informant interviews were low, often due to scheduling constraints. It is recommended that more qualitative data be collected to firmly settle on themes that the CPM and doula workforce highlight in the aforementioned topics.

Discussion

Demographics

The data analysis reveals indicators of contributing factors to maternal health care deserts, barriers to professional development for CPMs and doulas, challenges with compensation and Medicaid enrollment, as well as variable inclusion in formal health care settings. The quantitative analysis aligns with state assessments of maternal care deserts,[17] indicating that doulas and CPMs primarily provide services in Cook County and surrounding areas, with very few doulas and CPMs who provide services to birthing people further downstate and especially in southern Illinois. The data also demonstrates a lack of availability of racially concordant care. While there is more diversity among doulas than CPMs, efforts should be made to grow the workforce in ways that better reflect the identities of the patients they serve. This includes an intentional increase in Black, Latine, and Native American doulas and midwives.

Training and Support

84% of doulas report that the cost of additional training is too high. Furthermore, doula practice by nature is heavily responsive to the birthing person’s needs, including home visits, being on call, and attending births, which does not allow doulas to have a predictable schedule. Similarly, 69% of CPMs share the same type of challenges with costs, and 50% indicate not having time in their schedules. In addition, many doulas and CPMs are also parents and must navigate unpredictable childcare demands, particularly when they are on call. The community-based birthing workforce tends to provide services to clients in their homes, and doulas tend to provide services in clients’

homes and hospital settings. Thus, they are highly mobile, frequently responsive to clients, and do not work in settings that provide “on-call” relief or childcare support. While this workforce is highly dedicated to their clients, they are severely under-supported in their own professional development and work/life balance.

Compensation

Overall, CPMs and doulas especially tend to have wages below living wage limits, which requires them to work supplemental jobs to make ends meet. This contributes to burnout in a labor-intensive field because community-based birth workers take on many clients to cover living expenses. Essentially, doulas and CPMs need to be paid a livable wage, and many report that the current Medicaid reimbursement rate is insufficient to cover the full scope of the time and labor each client requires.

Current Medicaid reimbursement rates for doulas as of 2025 are $15 for 15 minutes of prenatal/postpartum patient education or other services (or $60 for one hour), $720 for labor and delivery support of a birthing person along with $50 for each postpartum visit (up to two visits), and $50 for a newborn visit within the first week.[15] Assuming that a doula provides all specified services and at least eight one-hour visits of perinatal education or other services, they would only be reimbursed for $1,350. This amount does not account for on-call time, travel time, and expenses, and the amount is the same per birth regardless of whether the labor was 40 minutes or 40 hours. According to our survey, 3 out of 4 doulas work with 20 or fewer clients annually, yielding an average annual revenue from Medicaid reimbursement of $27,000—far below what is considered a living wage in Illinois.

Doulas in a focus group shared that “$2,000 for each birth would be closer to a livable wage.” Similarly, CPMs, who provide extensive services to birthing people, indicate that they should be “compensated at least 10K per birth [as] it includes perinatal and postpartum services.” Furthermore, doulas and CPMs stated that the enrollment and billing processes for Medicaid are confusing and time-consuming. This presents an added burden on a workforce that is more physically mobile in community settings with limited time for extra administrative tasks.

Health System Integration and Social Support System Navigation

Doulas and CPMs noted consistent challenges with integrating into health care settings. In particular, many doulas in focus groups noted that their experiences with hospitals are “hit or miss,” meaning that there is a “fifty-fifty” chance that medical staff will be welcoming or respond with hostility. CPMs who were interviewed noted that most of their experiences with patient transfers are disjointed, and medical staff are sometimes antagonistic towards the CPMs and their patients. Overall, doulas’ and CPMs’ experiences of discrimination and exclusion pose a barrier to care for birthing people, especially those who are most vulnerable. Additionally, doulas and CPMs who were interviewed described witnessing human rights violations such as failure to obtain consent for vaginal exams, racism towards Black birthing people as they are not listened to, and judgmental attitudes towards birthing people who struggle with substance abuse.

Community-based birth workers also provide services to vulnerable populations, including those who experience substance abuse, domestic violence survivors, people with disabilities, immigrants, and people with insecure housing or who are unhoused. Many would like to provide more support to these populations if they had the training and resources. This requires more dedicated time for training, networking, professional development, and linkage with medical providers and social workers.

Overall, the data suggest that priority action steps should be taken to ensure the community-based birth workforce is expanded to meet the needs of birthing people racially, culturally, and in specific regions where there are maternal care deserts. Additionally, this workforce needs to be well supported with a livable wage, social support for burnout, childcare, and accessible, affordable professional development. Lastly, doulas and CPMs need better integration into health care and hospital settings with access to social support networks to provide more care and resources to vulnerable populations.

Recommendations

1. ***Building Capacity of the Community-Based Birth Workforce***

   "We need more birth workers to manage the load when one has to step away."

   "We need more tailored education…a deeper dive with cultural awareness."

   a. *Build Community-Based Workforce*: As previously mentioned, the community-based birth workforce needs to expand to meet the demand of birthing people across the state. Approximately 1,600 more doulas and CPMs are needed to provide perinatal services and support, especially in maternal care deserts and to vulnerable populations.
   b. *Ensure Racial Concordance*: There should be a focus on ensuring racially concordant care provided by doulas and CPMs. Black and Brown people who show an interest in birth work should be recruited to enter the workforce to increase diversity amongst doulas and midwives for culturally congruent care for Black and Brown birthing people.
   c. *Uplift Career Development*: Career pathways to becoming a community-based birth worker in Illinois must become more accessible, affordable, and financially sustainable.
   d. *Expand Community-Based Birth Workforce in Rural Areas*: Education and training to become a community-based birth worker should be more accessible in maternal care deserts throughout the state, including rural areas and areas with high rates of maternal morbidity and mortality.
   e. *Ensure Access to Professional Development*: Ongoing professional development for current community-based birth workers should be affordable and offered in

person, with online options available. Professional mentorship should also be offered to birth workers who are new to the profession.

2. ***Support and Sustainability for Community-Based Birth Workers***

"I enjoy being a doula, but I want more pay. I can't leave my other job because this doesn't pay enough."

"We need childcare at any time."

a. _Social Support for Community-Based Workforce_: Community-based birth workers need social and structural support that includes childcare support, health care, and behavioral health support to manage stress and improve mental health and well-being. Individual and group methods of mental health support should be developed to help address stress, burnout, workplace toxicity, and any other challenging experiences in the field or at home.

b. _Fair Compensation_: The livable wage for community-based birth workers should be fair for the labor they provide and reflective of all services they deliver to clients. The compensation for community-based birth workers should be sufficient to cover rent/mortgage, transportation, food, clothing, childcare, and other basic needs, as necessary.

c. _Medicaid Rate Updates_: The Medicaid reimbursement rate should be in parity with their counterparts in the medical field. Community-based birth workers have labor-intensive jobs that should be recognized by how they are compensated. Furthermore, if Illinois wants to grow this workforce, the job itself should allow a doula or CPM to manage life expenses without having to work other jobs to make ends meet.

d. _Medicaid Technical Assistance_: Community-based birth workers will need technical assistance and ongoing support to enroll in Medicaid and manage billing. Considering that this workforce yields an elevated level of external labor, administrative support and infrastructure should be built for billing and other management responsibilities to maintain the payment system and compliance with state requirements.

3. ***Integration into Health Care Settings and Wraparound Support Networks***

"We need to have a connection to all people involved in the birthing person's team...physicians, nurses, and birth workers."

"Patients need compassionate care from providers and continuity of care."

a. *Grand Rounds for Medical Providers*: Training and professional development should be given to health care and hospital system providers develop their understanding of how to work alongside community-based birth workers to improve maternal health outcomes. Training should include (but not be limited to) an overview of doula and midwifery professions, community and person-centered delivery of care, continuum of cultural humility, and informed consent.
b. *Systemic Changes for Better Maternal Health*: Healthcare administrators, medical providers, policy makers, community-based birth workers, and Illinois community members need a shared space to reshape maternal care delivery to be more transparent and accountable to the public, especially as it pertains to addressing racism and other forms of discrimination and disrespect in formal health care and hospital settings. Additionally, this redesign of maternal care should include a smooth process for transferring patients, expanding continuity of care at the community level, and better collaboration to provide support for vulnerable populations.
c. *Community-Level Perinatal Health*: Birthing care should include options for standardized services that can be safely provided in community or home environments. This will take some time, but an incremental approach for implementation should be developed and guided by data that doulas and CPMs collect with the clients they have served.
d. *Research and Evaluation*: Illinois needs a centralized place and process for evaluation, data collection, and dissemination to set metrics for progressive improvement of maternal health care and birthing outcomes.
e. *Continuity of Care for Vulnerable Populations*: Community-based birth workers need more collaboration with community-based organizations to provide clients with health-related and social needs resources that will improve their birthing and postpartum outcomes. Memorandums of understanding and linkage agreements should be used to state the terms and conditions of working collaboratively.
f. *State-wide Resource Hub*: Community-based birth workers need a community resource hub to connect their clients to birthing resources and other social service agencies that can assist them with accessible housing, access to nutritious food, help with substance use, help with intimate partner violence, support for immigrant communities, and other social supports as necessary.

4. Building Power in the Community-Based Workforce

"I'm positive, but the work is very tough on the mind…very stressful especially when you don't have all the resources you need."

"Seeing successful births for moms and babies has been life changing. Births are less violent…they didn't get yanked out."

a. *Community-Based Birth Worker Coalition*: Doulas and CPMs should continue to build a collective coalition that grows their power to push for fair wages, inclusion in maternal health and birth equity policies, and better integration in the maternal child health continuum.
b. *Bridges for Policy, Legislation, and Resource Allocation*: Additionally, to build the workforce, increase professional development opportunities, and sustain birth workers, some seasoned doulas and CPMs may need to run for office, serve on state-level advisory boards/working groups, become instructors/long-term mentors, or serve as a bridge between medical and community settings in newly defined roles.
c. *Linkage with Related Health Disparities*: Since equity requires constant movement building and linkages to other struggles for liberation, it is worth considering what other health equity initiatives share common goals for the improvement of health outcomes for oppressed populations and determine where there can be collaboration for greater public visibility and influence.
d. *Workforce Recognition*: Community-Based Birth Workers need a dedicated space for regular, public recognition and celebration of their positive impacts in the workforce, community, and the lives of birthing people.

*To get connected and learn more about the Community-Based Birth Justice Strategic Plan, visit the URL.

References

1. DONA International. What is a doula. DONA International. Published 2025. https://www.dona.org/what-is-a-doula-2/

2. Black Midwifery Collective. Become a midwife. Black Midwifery Collective. Published November 6, 2024. Accessed November 13, 2025. https://blackmidwiferycollective.org/become-a-midwife/

3. Handler A, Johnson K, James AR, et al. The multifaceted policy threats to maternal and infant health. Health Affairs Forefront. Published online 2025. doi:10.1377/forefront.20250808.41913

4. Gunja M, Gumas E, Masitha R, Zephyrin L. Insights into the U.S. maternal mortality crisis: an international comparison. The Commonwealth Fund. Published June 4, 2024. https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison

5. U.S. Bureau of Labor Statistics. Obstetricians and gynecologists. Bureau of Labor Statistics. Published April 25, 2023. https://www.bls.gov/oes/2023/may/oes291218.htm

6. U.S. Bureau of Labor Statistics. Family medicine physicians. Bureau of Labor Statistics. Published April 25, 2023. https://www.bls.gov/oes/2023/may/oes291215.htm

7. Spiess S, Owens R, Charron E, et al. The role of family medicine in addressing the maternal health crisis in the United States. J Prim Care Community Health. 2024;15. doi:10.1177/21501319241274308

8. Fontenot J, Lucas R, Stoneburner A, et al. Access to maternity care in Illinois. 2023:1-6. https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Illinois.pdf

9. Bergo C, Howland J, Masinter L, Nege J. Illinois maternal mortality data report. Illinois Department of Public Health; 2025:1-32.

10. Bennet A, Bergo C, Debelnogich J, Lightner S, Masinter L. Illinois maternal mortality and morbidity report. Illinois Department of Public Health; 2023:1-79. Accessed October 29, 2025. dph.illinois.gov

11. Chicago Department of Public Health. Maternal morbidity and mortality in Chicago. Chicago Department of Public Health; 2019:1-28. Accessed 2025. https://www.chicago.gov/dam/city/depts/cdph/statistics_and_reports/CDPH-002_MaternalMortality_Databook_r4c_DIGITAL.pdf

12. Hans SL, Edwards RC, Zhang Y. Correction to: randomized controlled trial of doula-home-visiting services: impact on maternal and infant health. Matern Child Health J. 2018;22(suppl 1):125. doi:10.1007/s10995-018-2626-7

13. Illinois Department of Public Health. Birth statistics. dph.illinois.gov. Published 2021. Accessed October 29, 2025. https://dph.illinois.gov/data-statistics/vital-statistics/birth-statistics.html

14. Press G. Gov. Pritzker releases Illinois Birth Equity Blueprint. The State of Illinois Newsroom. Published September 25, 2025. Accessed November 20, 2025. https://gov-pritzker-newsroom.prezly.com/gov-pritzker-releases-illinois-birth-equity-blueprint

15. March of Dimes. Fertility rates by race/ethnicity: Illinois, 2021-2023 average. March of Dimes | PeriStats. Published 2021. Accessed November 13, 2025. https://www.marchofdimes.org/peristats/data?reg=99&top=2&stop=4&lev=1&slev=4&obj=1&sreg=17

16. March of Dimes. Distribution of gestational age categories: Illinois, 2020. March of Dimes | PeriStats. Published 2024. https://www.marchofdimes.org/peristats/state-summaries/illinois?lev=1&obj=3®=99&slev=4&sreg=17&stop=55&top=3

17. Illinois.gov. Doula fee schedule. Published 2024. Accessed November 20, 2025. https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/doula.html